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Bentleigh East 3165
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NuWave Vascular Ultrasound

BULK-BILL
Imaging Request Form

Patient Name:_____ DOB_____

Address:_____

Phone Number:_____ Medicare:_____ Ref:_____

LOWER LIMB	☐ DVT	☐ Arterial	☐ Varicose Veins	☐ Graft		⬚ **RIGHT**
UPPER LIMB	☐ DVT	☐ Arterial	☐ Thoracic Outlet	☐ Arteriovenous Fistula	☐ Graft	⬚ **LEFT**
MAPPING (bypass)	☐ Leg Veins		☐ Arm Veins	☐ Pre-Fistula Creation		⬚ **BILATERAL**

HEAD/NECK ☐ Cerebrovascular ☐ Central Veins

ABDOMINAL ☐ Aortoiliac / IVC ☐ Renal Arteries ☐ Visceral Vessel **(4 HOUR FAST)**

PRESSURE STUDIES ☐ Resting ABI ☐ Exercise ABI ☐ Toe Pressures ☐ Finger Pressures

Clinical Notes:

Referrer Details:

Signature: Date:

Appointment Details:

This referral may be used with other imaging providers

BOOKINGS: 7038 - 0689